HIP ENHANCED SERVICES PLAN
FREQUENTLY ASKED QUESTIONS

What is the HIP-ESP Plan?

The HIP Enhanced Services Plan (ESP) is designated for certain individuals with health care conditions that require additional support. These conditions include internal cancers, HIV/AIDS, hemophilia, aplastic anemia and organ transplants.

How does a HIP member get into the ESP Plan?

The application for the HIP program includes a brief medical questionnaire, which asks applicants if they have had any of the above conditions. If the applicant answers yes to any of the medical conditions listed, the applicant signs a consent form that allows the State to obtain medical records information.

If the applicant answers yes to any of the medical questions, they are placed in the ESP plan so that they may begin receiving medical services immediately. The State will then contact the member's providers to verify the condition specifics and will make a final decision as to whether the member should remain in the ESP plan or should be sent to their original plan choice, as indicated on the application. The member will not experience a lapse in coverage.

Are there any pre-existing conditions exclusions? Is a person excluded from HIP if they answer 'yes' to any of the questions on the health questionnaire?

No. A person cannot be excluded from HIP based on their health condition. The purpose of the health questionnaire is to provide enhanced services to those participants that have serious medical conditions.

Should a person who answers 'yes' to any of the health questions still select an insurance carrier?

Yes. If the State determines that the person can be served by one of the traditional health plan carriers, they will be sent to the plan they chose. If there is no plan choice, the member will be randomly assigned to a plan.

How long will it take the State to make a final determination on a member's placement in the HIP-ESP plan?

The eligibility process, in combination with the HIP-ESP determination process, should take no more than 45 days. The State will contact the providers that the member lists in their application. The length of the process is dependent on the completion of a short provider questionnaire about the extent and duration of the member's illness.

How will a member know if they are going to be sent to another plan?

The member will receive a letter from Indiana Comprehensive Health Insurance Association (ICHIA) that indicates they are moving to a new plan. In addition, the new plan will also send a welcome letter. ICHIA will facilitate the transfer of all monthly contributions that have been paid to date to the new plan.

What if a person develops one of the health care conditions while on one of the other plans?

The insurance carriers have 30 days from the effective date of coverage to identify a member who may be eligible for ESP. After 30 days, the member will remain with their health plan through the duration of their membership term (12 months). During re-determination, if the member, insurance carrier and/or provider update the member health questionnaire to reflect the new condition, the member will be placed in the ESP plan.

What if a member's condition improves while on the HIP-ESP plan?

The member will remain with the ESP plan until the end of their coverage term at which time, the member or State may consider eligibility for a traditional health plan carrier.

What does the ESP plan offer? How is it different from the other plans?

The ESP plan includes a wide selection of providers throughout the State, as every Medicaid or Indiana Health Coverage Program provider is included in the network. Additionally, all ESP members will receive disease and case management services particular to their health condition. The ESP plan has experience with providing health care to persons with significant and serious health conditions.

Are the benefits any different in the HIP-ESP Plan? Do the HIP-ESP members have the same $300,000 annual and the $1 million dollars lifetime maximum?

The benefits under the HIP-ESP Plan are identical to benefits offered by the other traditional HIP carriers. HIP-ESP members are subject to the same annual and lifetime maximums. ICHIA and the State will identify members as they approach these maximums and will help them apply for other programs that they may be eligible for.

Do members still have to make monthly contributions? Will they have to contribute more?

A HIP-ESP member is still responsible for making monthly contributions and all relevant rules apply. A HIP-ESP member will not contribute any more under this plan than they would under any other HIP plan carrier.

Will the HIP ESP members have a POWER Account?

Due to the nature of the HIP-ESP member's health conditions, it is likely that their $1,100 POWER Account will be utilized very quickly. Therefore, their POWER Accounts will be handled slightly differently. HIP-ESP members will receive statements on their contributions and these contributions will be used to pay for the first $1,100 of non-preventive services. They will receive any payouts or rollovers if the amount of services they obtained is less than the amount they have contributed. HIP-ESP members will not receive monthly POWER Account statements but will receive an explanation of benefits for each service they receive and the cost of each service.

Who will operate the HIP-ESP Plan?

The State is contracting with the Indiana Comprehensive Health Insurance Association (ICHIA). ICHIA also operates the State's high-risk pool. ICHIA has contracted with ACS to handle member services and claims, as well as APS for disease management services. EDS will process all pharmacy claims for HIP-ESP members

Are HIP-ESP members considered a part of ICHIA?

No. ICHIA has vast experience with persons with significant and serious health care conditions and was designated by the Legislature to serve HIP members with high-risk conditions. The HIP-ESP members are not a part of the traditional ICHIA program but will receive disease and case management services similar to those received by other ICHIA members.

FOR PROVIDERS

Which providers are in the HIP-ESP network?

All Indiana Medicaid providers or Indiana Health Coverage Program providers are eligible to provide services for HIP-ESP members.

Where should providers send claims?

Health care providers who see a HIP ESP member should send all claims other than pharmacy claims to ACS. Pharmacies should send all ESP claims other than claims for Durable Medical Equipment to EDS.

- **All Claims Other than Retail Pharmacy Claims**
  Mail to ACS at ESP (ACS) P.O. Box 33077 Indianapolis IN 46203-0077
  Call ACS at 317-614-2032 to enroll for electronic claims processing

- **Retail Pharmacy Claims**
  Pharmacy providers can submit all pharmacy claims via point of sale using the NCPDP version 5.1 format. EDS also accepts pharmacy batch claims submitted via the NCPDP 1.1 batch claim format. Go to http://www.indianamedicaid.com/ihcp/TradingPartner/EDI_ImplProc.asp h for instructions on how to sign up with EDS for electronic batch claims processing.
  The payer for both the NCPDP 5.1 and 1.1 transactions is located at www.indianamedicaid.com. Click on the pharmacy services tab to download a copy of the payer sheet. Providers can also mail paper pharmacy claims to EDS at the following address:

  EDS
  P.O. Box 7268
  Indianapolis, IN 46207-7268

  Visit www.indianamedicaid.com and click on the forms link to download copies of the pharmacy claim forms.

What about prior authorization and utilization management requirements? Where can providers go for additional information?

Prior authorization and UM requirements can be found in the ACS HIP Provider Manual. This can be found on the internet on the ESP website at hip-esp.org.

What rates will providers be paid?

Per the HIP enabling legislation, HIP providers will be paid at Medicare rates. If a Medicare rate is not available, claims will pay 130% of the current Medicaid rate. Pharmacy providers will be reimbursed according to the Medicaid fee schedule.

Are pharmacy claims reimbursed differently?

Yes. The reimbursement guidelines for HIP-ESP pharmacy claims will be consistent with the current Indiana Medicaid reimbursement. To view these guidelines, providers can reference Chapter 9 of the Indiana Heath Coverage Programs provider manual.